OCCIPITO-POSTERIOR POSITIONS*.

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DURING a somewhat limited practice in obstetrics, derived from a general practice extending over a period of something like sixteen years, there perhaps has been no particular line of cases that has given me so much annoyance as those which have presented themselves in occipito-posterior position.

In looking up the matter in the various text-books, it has seemed that the literature upon the subject is more meager than the importance of this class of cases deserves. The majority of text-books devote from one to three pages to the subject. One is impressed with the fact that more attention in the classroom, more explicit directions in the text-books, and more thought in general upon the subject, by the young practitioner especially, would be the means of putting him in a better position to properly handle these trying cases that so often result in more or less injury to the maternal parts and not infrequently result in death to the new-born. For instance, Lusk, in his most admirable system of midwifery, devotes only one and one-half pages to the subject, but throws a vast amount of light upon the mechanism of rotation in such cases by a quotation (which will be given later on) from Dubois. Carrigues is somewhat more explicit in his handling of the subject, devoting three pages which form a most commendable article upon the subject.

King in his little "Manual of Obstetrics," devotes about three pages to occipito-posterior presentations, and handles the topic very masterfully. He holds that about 96 per cent. of these cases correct themselves by being transformed into occipito-anterior positions before delivery is completed. He furthermore claims that in the remaining 4 per cent. much may be found to aid anterior rotation, especially where an early diagnosis is made. Later on, his expedients to promote anterior rotation will be quoted. Grandin and Jarman, in the third edition of their "Practical Obstetrics," devote about three pages to occipito-posterior positions, and a liberal quotation from them will be made later.

In being called in as consultant in a difficult obstetrical case, it is not of unusual occurrence to find that a long-protracted case, which is about to be terminated with instruments, is due to this faulty position; and it is not of infrequent occurrence that the faulty position has not suggested itself to the attendant. While perhaps up to the time of such consultation no procedure could have resulted in a conversion to an anterior position, yet with a true understanding of the faulty position, the attendant would have been less impatient of delivery and would have given, ordinarily, a more guarded prognosis as to the eventual outcome. While these cases will possibly often correct, or partially correct, themselves if time be given, it is somewhat questionable as to how much good we can accomplish by interference. The slow advancement of the head; labor usually attended by more than the ordinary amount of pain; necessity for an unusual amount of patience; the frequency with which partial or complete laceration of the perineum occurs; the amount of pressure that is necessarily made upon the cranium of the child by the forceps; and the frequent need for immediate repair of the perineum are points well worthy of consideration. As pointed out by Grandin, "a tedious first stage, characterized by short, nagging pains, is a fairly uniform accompaniment of the instances which should cause anxiety." It is here that a careful manual examination, taking into account later on in the course of labor the exact positions of the two fontanels, should enable us to arrive at a correct diagnosis.

As I have intimated before, the following experiments of Dubois, taken from Lusk, give us a clew to the part played by the perineum in the anterior rotation which not infrequently takes place when an abundance of time is given:

In a woman who had died a short time previous in child-bed, the uterus, which had remained flaccid and of large size, was opened to the cervical orifice, and held by aids in a suitable position above the superior strait; the fetus of the women was then placed in the soft and dilated uterine orifice in the right occipito-posterior position. Several pupil-midwives, pushing the fetus from above, readily caused it to enter the cavity of the pelvis; much greater effort was needed to make the head travel over the perineum and clear the vulva; but it was not without astonishment that we saw, in three successive attempts, that when the head had traversed the external genital organs, the occiput had turned to the right anterior position, while the face had turned to the left and to the rear; in a word, rotation had taken place as in natural labor. We repeated the experiment a fourth time, but as the head cleared the vulva the occiput remained posterior. Then we took a dead-born fetus of the previous night, but of much larger size than the preceding; we placed it in the same conditions as the first, and twice in succession witnessed the head clear the vulva after having executed the movement of rotation. Upon the third and following essays, delivery was accomplished without the occurrence of rotation; thus the movement only ceased after the perineum and vulva had lost the resistance which had made it necessary, or, at least, had been the provoking cause of its accomplishment.

Now, if we accept these experiments of Dubois, together with the statement of King that 96 per cent. of posterior positions correct themselves, are we justified in radically interfering, as Grandin suggests, long before the head reaches the perineum? Here I quote at length from page 418 of the latter's most commendable work:

For the purpose of rotation nothing can take the place of the aseptic hand, aside from the fact that at one and the same time the hand may detect any additional anomaly hitherto unsuspected, such as pelvic deformity, which, aside from being a further

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cause of slow or impossible engagement, may alter the field of election at the very best time (from the standpoint of both the woman and the fetus)—that is to say, when the conditions are still favorable for version or some other procedure. When the occiput rotates backward into the hollow of the sacrum, we are face to face with what—there is uniform agreement— constitutes one of the most difficult cases in obstetrics. The clean, educated obstetric hand at the pelvic brim is a source of positive safety to both the mother and child, compared with waiting until exhaustion calls for, for instance, the forceps within the pelvic brim. A tedious first stage, characterized by short, nagging pains, is a fairly-uniform accompaniment of the instances which should cause anxiety. It seems clear that manual examination at this time will often lead to the adoption of a procedure which will alter the prognosis of and lessen the difficulties attendant upon the persistent oblique and sacro-rotated occipital position. This procedure, which has been persistently advocated by the authors, has been much criticized on the ground, first, that internal rotation of this nature is not permanent, and, secondly, that, dilatation having been accomplished and the hand being in the uterus, the wiser plan is to perform podalic version. The first objection falls to the ground in face of the established fact that over and again the maneuver has succeeded. Those who fail simply twist the head. They do not rotate the body. The second objection carries more weight, and when the dystocia is due to the pelvis and not to the fetus its truth is now granted. But, if the size of the fetus added to the malposition is the cause of the tedious labor, it will be found advantageous in all instances except those of emergency to give nature a chance to dilate the pelvic canal, as also to mold the fetal head. It is a sound obstetric rule not to interfere needlessly either by forceps or version.

The following statement by King in his Manual is so pertinent and lucid as to the management of these cases that I cannot do better than quote in full as follows:

Various expedients have been devised to promote anterior rotation of the occiput when it does not occur spontaneously. Thus, since we know posterior rotation is generally the result of imperfect flexion (the forehead being too low, the occiput too high), we may strive to remedy the difficulty by making the flexion perfect. This can be done by pressing two fingers of one hand upon the forehead during the pains so as to push it up, or at least keep it from coming lower, while the force of uterine contraction is then expended in depressing the occiput. A vectis may at the same time be applied over the occiput to assist in pulling it down. The object is to get the occiput so low that it will pass below the spine of the ischium to the anterior inclined plane and rotate forward, while the forehead is kept high enough to pass above the opposite ischial spine and rotate backward. Rotation forward may sometimes be accomplished with forceps while making traction. If the pelvis be large and the operator's hand small, the latter may be passed in alongside of the head, and the occiput drawn obliquely downward and forward to the pubes. Another plan: Etherize to full anaesthesia. Pass a hand into vagina; grasp head, and steadily and gently push it up out of the pelvis, above superior strait. Then flex it, and rotate occiput forward. Hold it so until the pains, aided by pressure of other hand on abdomen, push it down again into pelvis, in its now occipito-anterior position. Forceps may be required to complete the delivery.

In conclusion we may say that (1) occipito-posterior presentations are tedious and painful, and form one of the most disagreeable classes of obstetrical cases. (2) That an early diagnosis of the position is desirable. (3) That there is often a question as to the best method of dealing with them. (4) Abundant time should be given when practicable, before applying forceps. (5) In using the forceps, tractions should be made with the handles as low as possible and pressure on the head should be frequently released. (6) The perineum is frequently, partially or completely lacerated and should be repaired at once.

DISCUSSION.

Dr. D. A. Hodghead, San Francisco — I am very sorry that Dr. Briggs is not present to open this discussion. This is a very interesting paper, and the question is a very important one, because the condition is extremely difficult to handle. I wish to compliment Dr. Cole upon the excellence of the paper, and to call attention to a few points. First, as regards the first stage of labor. In all these cases of malpresentation, the first stage is tedious, and I wish to emphasize this fact—the old theory of *rigid os*, which the obstetricians have talked so much about, except in cases of malignancy, is probably a myth. Bear this in mind, that when you have a tedious first stage, you have a malpresentation. That is the time to determine whether there is a malpresentation or not. If the head is properly presenting, you will not have rigidity of the cervix. As to rotation, we know that the true mechanism of the occipital presentation is extreme flexion, rotation of two-fifths of a circle, becoming the occipito-anterior, and then the normal mechanism. There are two rules as to the course of these cases, or as to why this rotation takes place. One is that the body will move in the direction of least resistance and in connection with that, the most dependent portion of the presented part will always rotate to the front. We can do away with the planes of the ischium. They cut very little figure in the rotation of the head. The point is to secure extreme flexion by some method; by pressing on the forehead or bringing down the occiput. Now as to interference. I would not allow that to stand in the way too long for these reasons: That too long a continuance of the second stage is dangerous to the mother and to the child by pressure on the head. If you do interfere with the use of forceps, place them in position just as in any other case, but before locking the instruments, I bring them down upon the perineum well and then, before making traction, lift the handles, and improve the flexion. If you can secure the head by means of the forceps you can increase the flexion, and then by making traction, can bring the head firmly down on the perineum. When you remove the instrument the rotation will take place itself. I can remember in the first case I ever had with occipito-posterior position, I did just this thing—pressed the forceps back against the perineum before locking, and then elevated somewhat, and brought the head against the floor of the pelvis, then removed the instruments, and the head rotated. This rotation will take place very quickly if you get the flexion extreme and the head down on the perineal floor.

Dr. Z. Malaby, San Francisco—The point that is usually neglected in these cases is abdominal palpation. It should be part of the routine in all cases. I have been instructing the students in the last few years to practice abdominal palpation in all cases.

When you get a case that is going to be one of posterior presentation, if you diagnose it early it is possible to rotate the head before it is engaged.

Dr. Geo. Cole, Los Angeles—Within a day or two before coming here I saw an article on the same subject. In speaking of these cases the writer advised two maneuvers: One was that as soon as the diagnosis was made in the early stage, the patient should remain in genu pectoral position and that the position of the body would often help to a better position, which I think is overdrawn, because I think the change of position takes place in the early stages, not when the head gets down near the perineum. But as to whether that position is of benefit or not, I am not able to say. The other suggestion was, in applying the forceps put them on in the reversed position; put the convexity to the front. His object in doing that was to make more perfect flexion. The point of the blades were pointed down directly toward the rectum, and while in the hands of a very suitable man this might be tried, yet to my mind it would simply result in injury to the rectum. In many cases we find a position where there is a large roomy pelvis and moderately sized child. Leave them to nature and the application of forceps becomes an easy matter. But where there is a small pelvis and a large child, it is exceedingly difficult.

WAS IT A CASE OF MENINGEAL HEMORRHAGE, HYSTERIA OR MALINGERING?*

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TO the general practitioner the obscure cases of hysteria and the cases of malingering are often embarrassing and sometimes hurtful. Until the stability of the nervous system is greatly increased and cupidity as greatly decreased, we may expect to find cases of hysteria and malingering. Medico-legal literature contains abundant evidence of the credulity and ignorance of physicians when dealing with hysterical and malingering patients. A study of the following case may assist us in our efforts to learn how to escape from the pitfall of hysteria and the tricks of the malingerer.

It should be known at the outset that the patient is a medical gentleman who has done much surgical work, and who is familiar with the anatomy and physiology of the human body, and is thereby more capable of deceiving his medical attendant than the untutored person would be. There is also a psychological possibility in the case which should not be overlooked. The patient is carrying an accident insurance policy which gives an indemnity of $100 per week for a period of 102 weeks. Should the disability of the policy-holder continue through that period, the accident company will be liable for the sum of $10,400. The question before us is not whether the company is liable, this being a purely commercial question, but whether the hope of gain has psychologically caused the patient to exaggerate his sufferings without being guilty of intentional wrong.

Fifteen physicians, all gentlemen of ability, have seen this patient, and at least two of the number have recently expressed themselves as believing the patient was not seriously injured. Of the others, one said: "It is a case of concussion of the brain"; another said: "It is a case of voluntary convulsions," and three said: "It is a case of meningeal hemorrhage," while another said: "It is a case of shock resulting in hysteria, or traumatic hysteria."

The opinions of these medical gentlemen are not to be pooh-poohed, for they are the opinions of men who have much diagnostic ability. Unfortunately, one of these medical gentlemen, who studied the case for several weeks, expressed an opinion which called in question the veracity and honesty of the patient, and incurred the displeasure of the patient's wife, who gave the doctor a public horsewhipping. The patient's family history contains nothing of importance in this connection. The personal history shows a large and varied experience in the affairs of life. He lost a little finger and the corresponding metacarpal bone of the left hand, through a gunshot wound. He had septicemia a few months before the present illness. From this he completely recovered, except that it left the skin of the anterior portions of his chest quite discolored by irregularly deposited pigment. At the time the injury, the effect of which we are to study, was received, he was in the full vigor of manhood, at the age of fifty-nine.

July 8th, 1902. While riding in a railway coach, with his elbow on the open window sill and his chin in his hand, he cried out that something had struck him and that he was in great pain. A physician, who was near, found a bluish colored, irregular circular spot about one inch in diameter, over the right coronal suture, about three inches below the median line of the head. There was no abrasion, nor did palpation give any evidence of fracture of the skull. A stone the size of a man's fist was found near the patient. At the end of about twenty minutes the patient lost consciousness, and had a number of convulsions, general in character. The comatose condition continued for 36 hours, during which time patient had many convulsions. At the end of 48 hours his mind was clearing, the pupils were dilated and left hemiplegia was discovered.

On the 5th day he had difficulty in speaking, but the nurse's notes do not disclose the nature of the difficulty. The convulsions continued to recur at irregular intervals.

On the 7th day the temperature, which before had been normal, rose to 100 2-10, pulse 74, respiration 27. He complained of pain in right side of head and in right ear. During the convulsions, which were less severe than at first, the facial muscles twitched and froth appeared between the lips.

The notes do not state whether the muscles on the left side of the body were involved in the convulsive movements at that time or not.

On the 8th day the temperature was 100, pulse 66, mind weak.

The 9th day the patient had 33 convulsions. He was always unconscious during these paroxysms.

The 12th day, ophthalmoscopic examination showed normal or slightly pale fundus, nothing wrong with the media, but there was hemiopsia of nasal side of right eye, the vision of left eye being undisturbed.

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